General Assembly

Raised Bill No. 5905

February Session, 2008

LCO No. **2854**

*02854_____HS_*

Referred to Committee on Human Services

Introduced by:
(HS)

AN ACT MODIFYING THE DEFINITION OF PREFERRED PROVIDER NETWORK AND CLARIFYING CERTAIN PROVISIONS OF THE CHARTER OAK HEALTH PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (7) of subsection (a) of section 38a-479aa of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

(7) "Preferred provider network" means a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical

laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, **[**or**]** (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan, or (v) a nonprofit organization providing services only to recipients of public assistance programs, including, but not limited to, the Medicaid program, the state-administered general assistance program and the Charter Oak Health Plan.

Sec. 2. Section 17b-311 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

(a) There is established the Charter Oak Health Plan for the purpose of providing access to health insurance coverage for state residents who have been uninsured for at least six months and who are ineligible for other publicly funded health insurance plans. The Commissioner of Social Services may enter into contracts for the provision of comprehensive health care for such uninsured state residents. The commissioner shall conduct outreach to facilitate enrollment in the plan.

(b) The commissioner shall impose cost-sharing requirements in connection with services provided under the Charter Oak Health Plan. Such requirements may include, but not be limited to: (1) A monthly premium; (2) an annual deductible not to exceed one thousand dollars; (3) a coinsurance payment not to exceed twenty per cent after the deductible amount is met; (4) tiered copayments for prescription drugs determined by whether the drug is generic or brand name, formulary or nonformulary and whether purchased through mail order; (5) no fee for emergency visits to hospital emergency rooms; (6) a copayment not to exceed one hundred fifty dollars for nonemergency visits to hospital emergency rooms; and (7) a lifetime benefit not to exceed one million

dollars.

(c) The Commissioner of Social Services shall provide premium assistance to eligible state residents whose gross annual income does not exceed three hundred per cent of the federal poverty level. Such premium assistance shall be limited to: (1) One hundred seventy-five dollars per month for individuals whose gross annual income is below one hundred fifty per cent of the federal poverty level; (2) one hundred fifty dollars per month for individuals whose gross annual income is at or above one hundred fifty per cent of the federal poverty level but not more than one hundred eighty-five per cent of the federal poverty level; (3) seventy-five dollars per month for individuals whose gross annual income is above one hundred eighty-five per cent of the federal poverty level but not more than two hundred thirty-five per cent of the federal poverty level; and (4) fifty dollars per month for individuals whose gross annual income is above two hundred thirty-five per cent of the federal poverty level but not more than three hundred per cent of the federal poverty level. Individuals insured under the Charter Oak Health Plan shall pay their share of payment for coverage in the plan directly to the insurer.

(d) The Commissioner of Social Services shall determine minimum requirements on the amount, duration and scope of benefits under the Charter Oak Health Plan, except that there shall be no preexisting condition exclusion. Each participating insurer shall provide an internal grievance process by which an insured may request and be provided a review of a denial of coverage under the plan. Each participating insurer shall be considered to be performing a governmental function, as defined in subdivision (11) of section 1-200.

(e) The Commissioner of Social Services may contract with the following entities for the purposes of this section: (1) **[**A**]** Any organization authorized to do health insurance business in this state; (2) a health care center subject to the provisions of chapter 698a; **[**(2)**]** (3) a consortium of federally qualified health centers and other

community-based providers of health services which are funded by the state; or **[**(3)**]** (4) other consortia of providers of health care services established for the purposes of this section. Providers of comprehensive health care services as described in subdivisions **[**(2)**]** (3) and **[**(3)**]** (4) of this subsection shall not be subject to the provisions of chapter 698a. Any such provider shall be certified by the commissioner to participate in the Charter Oak Health Plan in accordance with criteria established by the commissioner, including, but not limited to, minimum reserve fund requirements. Any entity entering into a contract for the purposes of this section shall be licensed by the Insurance Department if required by any provision of the general statutes to be so licensed.

(f) The Commissioner of Social Services shall seek proposals from entities described in subsection (e) of this section based on the cost sharing and benefits described in subsections (b) and (c) of this section. The commissioner may approve an alternative plan in order to make coverage options available to those eligible to be insured under the plan.

(g) The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies shall be valid until the time final regulations are adopted and may include: (1) Exceptions to the requirement that a resident be uninsured for at least six months to be eligible for the Charter Oak Health Plan; and (2) requirements for open enrollment and limitations on the ability of enrollees to change plans between such open enrollment periods.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2008*	38a-479aa(a)(7)

Sec. 2	*July 1, 2008*	17b-311

Statement of Purpose:

To exempt nonprofit organizations providing services only to public assistance recipients from the requirements of licensure as a preferred provider network and to clarify certain provisions relating to insurer participation in the Charter Oak Health Plan.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]